

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC Requestor's Name and Address Dr. David Rabbani 7447 Harwin, Ste 190 Houston, TX 77036	Response Timely Filed? (x) Yes () No MDR Tracking No.: M4-05-3209-01 TWCC No.: [REDACTED] Injured Employee's Name: [REDACTED] Date of Injury: [REDACTED] Employer's Name: [REDACTED] Insurance Carrier's No.: [REDACTED]
Respondent's Name and Address American Home Assurance Co	BOX #: 19

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-06-04	10-08-04	97110	\$74.08	\$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's position statement received, 01/17/05, states in part..."The original carrier's denial of the services rendered on October 06 & 08, 2004 was based on the Payment Exception Code "F." Furthermore, the carrier failed to respond to our request for reconsideration of December 13, 2004. Hence, we submit that the carrier's "new" reason for the denial is untimely and irrelevant."

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent's position statement received, 01-17-05, states in part..."One-on-one therapy requires a physician or a qualified staff member to exclusively supervise the patient during the course of therapy. It does not permit the supervising person to be involved in other activities including supervision of other patients."

One-on-one therapy is an educational component of care. One-on-one therapy is an educational component of care. One-on-one therapy generally is not needed once a patient can demonstrate proficiency in the performance of his/her exercises or unless a provider sees the need to prescribe a change.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The insurance carrier denied 97110 with "F-submitted documentation does not support or meet the criteria for one-on-one therapy that is identified in Fee Guideline Ground Rules and/or CPT code descriptor for reimbursement."

Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

PART VI: DETAIL FINDINGS (If needed)

N/A

PART VII: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **NOT** entitled to additional reimbursement and therefore declines to issue an Order for payment.

Ordered by:


Authorized Signature

Patricia Rodriguez

Typed Name

06-07-05

Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on 6-8-05. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____